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ELDER ABUSE

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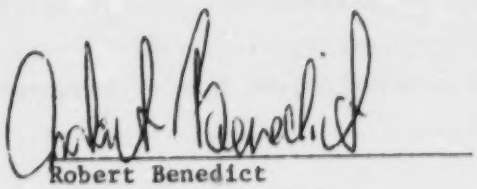
FOREWORD

Abuse of older persons by their own families is a problem which has recently emerged as a national concern. Such abuse is not new; what is new is an awareness of the problem and a growing desire on the part of society to rectify it.

This report, prepared in response to that concern, endeavors to inform the interested public about some of the research that has been conducted to date on this subject. The research includes two studies sponsored by the Administration on Aging which explore the development of approaches to assess the problem of abuse. Two other studies on abuse are also examined. Additional sources are cited and listed in the bibliography.

The 1960's and 1970's were the decades of emerging awareness of the problems of child abuse and spouse abuse. Hopefully, in the 1980's the issue of elderly abuse will become a priority social concern and significant action will be taken to respond to the human needs which must be served. This publication is intended to assist such action with information from relevant research findings.



Robert Benedict
Commissioner on Aging

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Introduction

"It may well be that the 1980s will herald the 'public' awareness of the battered aged -- elderly parents who reside with, are dependent on, and battered by their adult, caretaking children."

Suzanne Steinmetz, author of the article "Battered Parents" suggests that the 1960's and 1970's were the decades of awareness of child abuse and wife-beating, respectively. She notes that, while these abuses are at least as old as recorded history, "only recently has the public demanded protection for these categories of individuals considered to be economically dependent, politically weak, and lacking in legal protection."[1]

Now it is time to focus on another weak or dependent family member, the abused parent, to increase the awareness of the existence of abuse of the elderly, and to reach out to this group, offering assistance and protection. The recognition of the potential value of research as a basis for practitioner intervention and as a basis for program, policy, and legislative recommendations initiated a search for elderly abuse research.

Very little was found, as little research had been conducted in this area, beyond the identification of a critical need for specific investigation into the phenomenon of violence between middle-aged adults and their elderly parents.[2]

The bulk of available information concerning the elderly abused is in the form of anecdotal data and media coverage of the phenomenon. However, the search did uncover four research and analytical efforts of potential value to the gerontological field:

- The Battered Elder Syndrome: An Exploratory Study, edited by Marilyn R. Block and Jan D. Sinnott, aimed at determining the feasibility of different approaches to investigating the nature

and incidence of the maltreatment -- including neglect and physical or mental abuse -- of older Americans.

- The Massachusetts Legal Research and Services for the Elderly demonstration project, which attempts to document the incidence of elder abuse (Elder Abuse in Massachusetts: A Survey of Professionals and Paraprofessionals) and to analyze the legal (Legal Analysis) and social service (Service Systems Analysis) response systems.

- An exploratory study by Elizabeth E. Lau and Jordan I. Kosberg -- "Abuse of the Elderly by Informal Care Providers," in Aging September-October 1979 -- providing characteristics of the abused elderly, defining abuse, and exploring theories on the causes of abuse, outcomes of professional assistance, and practice, policy and legal implications.

- A Michigan pilot project -- A Study of Maltreatment of the Elderly and Other Vulnerable Adults -- which, among other objectives, sought to determine whether the phenomenon was of sufficient magnitude to justify the investment of scientific, professional and governmental resources in studies of its characteristics and possible remedies.

The framework for this paper is the research studies themselves -- their findings and key questions concerning elderly abuse covered by one or more of the cited sources. An appropriate beginning is to define the term "abuse." Attention is then directed to study methodology and findings in terms of incidence of abuse and the forms abuse takes; characteristics of the abused, the abuser, and the professionals and paraprofessionals identifying elderly abuse; and intervention efforts. Elderly abuse is considered in the context of violence in America and in the American family. Potential causes of abuse are reviewed. The final focus is on the issues raised by these research and analysis efforts in the context of their implications for legal, social, and preventive intervention and public policy formulation.

THE STUDIES

Defining Abuse

The definition and clarification of the term "abused elderly" is critical to this discussion. There is considerable agreement in the use of the term as it is defined by the four research studies. In The Battered Elder Syndrome: An Exploratory Study, victims of abuse were defined as those individuals "who had sustained physical, psychological, material or medical abuse in the home; had a repeat history of such injury; were at least 60 years of age; and resided in the home of a son or daughter, other relative, or with a caretaker."[3]

Lau and Kosberg wrote that the elderly person may live alone, in his or her own home with the abuser, or in the abuser's home and that the abuser may be a close or a distant relative, a friend, or a neighbor. They describe four categories of abuse:

- Physical -- beating; withholding personal care, food and medical care; and lack of supervision
- Psychological -- verbal assault and threats, provoking fear, and isolation
- Material -- monetary or material theft or misuse
- Violation of rights -- forceful eviction from victim's residence and relocation in another setting.[4]

In "The Massachusetts Study" abuse was defined for survey purposes as "the willful infliction of physical pain, injury or debilitating mental anguish, unreasonable confinement or willful deprivation by a caretaker of services which are necessary to maintain mental and physical health."

Elderly is defined as any individual age 60 or older who is residing in a non-institutional setting, including persons living alone, with family or friends, or with a caretaker. The definition excludes self-neglect. Only Lau and Kosberg include self-abuse as a category of abusing persons.

In its most severe form, willful neglect is difficult to distinguish from physical abuse. However, the Massachusetts survey attempts to obtain information on this phenomenon by stipulating that the neglect must be willful, i.e., intended. The authors note that, because "intentions" are difficult for an observer (in this instance the survey respondent) to determine, the broadening of the definition increases the possibility that survey responses will include other and less willful forms of neglect.[5]

The inclusion of such forms of neglect is the intention in the Michigan pilot study. In their effort to examine the respondents' perceptions of the extent to which the needs of dependent adults are met by those on whom they depend and of the extent of neglect and abuse, questions were developed to measure "need," "neglect," and "abuse."

The categories were passive neglect (ignored, left alone, isolated, or forgotten), active neglect (withholding of companionship, medicine, food, exercise, or assistance to the bathroom), verbal or emotional abuse, physical abuse, or abuse leading to severe injury or death.

The focus in the Michigan study was not on the elderly alone but on "vulnerable adults," a category which included the elderly, the mentally retarded, the emotionally impaired, and the physically handicapped. A secondary analysis was made of data regarding neglect/abuse of nursing home patients.[6]

In sum, it is important to clarify the focus of concern when considering intervention relevant to the abused elderly. Without disregarding the

importance of self-abuse, abuse of the institutionalized, and other categories of vulnerable adults, these preliminary research efforts (along with other research in the field of family violence to be reviewed later) support concentration at this time on a specific group: individuals aged 60 or older who live either alone or with a family member, a friend, or other relative or caretaker in the community and who are victims of abuse in the home -- physical, psychological, material, medical, or violation of rights.

Study Methodology and Incidence of Abuse

Survey techniques and retrospective analysis were used in The Battered Elder Syndrome: An Exploratory Study in an attempt to establish preliminary estimates of the prevalence of abuse in the elderly population and to provide a description of the syndrome. Senior day centers and home care programs were used as target groups for survey information. Three data collection approaches were employed, and information about the feasibility of each of these approaches was gained.

Under Plan A, agencies which serve the elderly in that portion of the State of Maryland included in the greater Washington, D.C., Standard Metropolitan Statistical Area (SMSA) and the city of Baltimore were contacted. Included were county police departments, adult protective service agencies, senior centers, and home care programs.

The agencies were contacted by mail or by phone to solicit the confidential use of records. An advisory board of representatives from these agencies was established to supervise the use of records, to select key agency informants, and to obtain desired records for project use through proper agency channels.

Plan B involved a mail survey of nurses, doctors, social workers, and senior program personnel in the greater Washington, D.C., SMSA, randomly selected from professional organization membership lists. These professionals were asked to describe elder abuse cases of which they had first-hand knowledge.

Information was sought from the elderly themselves in Plan C. Residences were randomly selected from 11 of the 627 census tracts in the greater Washington, D.C., SMSA. The forms that were used in Plans A, B, and C are included in the report as an appendix.

Only one agency contacted in Plan A delivered useable data, despite promised cooperation. The best rate of response was in Plan B: 134 individuals responded, a rate of 31.38%, after one follow-up request for data. Of the professionals responding, 13.43% reported cases of abuse, 4.22% of those sampled.

Block and Sinnott note that elder abuse may be a greater problem than is indicated by these responses, since 87.93% of respondents not reporting a case indicated hearing of an abuse case which they declined to report. Only 12.07% had never heard of elder abuse as a social/medical problem.

Of the 433 elderly contacted in Plan C, 73 or 16.48% responded. Of those responding, 4.1% reported abuse, or 0.7% of those sampled. Four cases were reported under Plan A; 19 under Plan B; and 3 under Plan C.[7]

The Massachusetts report is based on data gathered during March and April 1979 in a survey of 1,044 medical, legal, police, and social work professionals and paraprofessionals. The authors' hope is that the descriptive information obtained will be useful in designing further analytical studies on the extent of elder abuse and the variables associated

with the phenomenon and in raising the awareness of professionals and paraprofessionals in recognizing abuse in their diagnosis of elderly clients.

A total of 355 of 1,044 stamped, self-addressed questionnaires were returned, a response rate of 34%. Of those returned, 19 were eliminated because more than one citation of abuse was reported on the form, thus complicating data tabulation. Four additional responses were eliminated for lack of clarity. Of the remaining 183, 55% cited cases of abuse within the past 18 months. When multiple-incident responses (those which were eliminated from the analysis) are included, the percentage of returned surveys that cite abuse rises to 57%. No abuse was reported in 149, or 22%, of the returned questionnaires. The survey form is included in the report.[8]

Lau and Kosberg's exploratory study of abusive behavior was conducted at the Chronic Illness Center (CIC) of the County Hospital System in Cleveland, Ohio, in an effort to determine the incidence and nature of abuse in cases accepted by that agency. CIC serves aged and chronically ill clients in the community by providing assessment, counseling, and assistance on an individual basis and employing community resources to plan for care. The focus is on direct services, particularly in the area of home care.

Agency workers were asked to review all clients over age 60 (both closed and active cases) for instances of physical, psychological, and material abuse during the period June 1977 through May 1978. During that period, a total of 484 new cases were accepted by CIC. Of these, 404, or 86%, were age 60 or older. A total of 39 cases of abuse were identified, representing 9.6% of all elderly clients seen by the agency in the course of the year. Lau and Kosberg suggest that, because staff had not been alerted to detect and record abuse until after the fact, the prevalence of abuse found in this study may be

underrepresented. Case records on the 39 abuse cases became the basis for information.[9]

Five sites were involved in the Michigan pilot study, representing metropolitan, suburban, agricultural, and isolated areas and heterogeneous ethnic and varied socioeconomic sub-populations. Questions regarding neglect and abuse of "vulnerable adults" were asked of individuals with substantial and relatively constant exposure to the service needs of people residing in their jurisdictions. Survey categories included private and public attorneys, physicians, nurses, mental health workers, caseworkers (such as social workers, adult service workers, and services to the aging personnel), morticians, coroners and their field staffs, police officers and detectives, and clergy.

The sample selection process required the development of profiles of study sites with regard to each survey category, which identify respondents, agencies, organizations, client populations, and services provided. Selection of respondents within the profiles was accomplished by contacting potential respondents for an interview. One-hour interviews were conducted with 228 respondents from February to May 1979. The sample size for most questions was 228. Survey questions dealt with the general status of the vulnerable adults they had encountered, the degree to which their needs are met, and finally, the frequency of physical abuse.

Respondents were encouraged to elaborate on their perceptions of the well-being of the vulnerable groups with which they were most familiar. It was possible to codify some of these responses into the broad categories of passive neglect, active neglect, verbal or emotional abuse, and physical abuse.

Of the 228 respondents, only 77, or 38.7%, reported no experience with physical abuse. (In general, passive neglect and verbal or emotional abuse

were the abuses most frequently reported.) Even fewer respondents had no experience with other categories of neglect and abuse. The authors report that, while the incidence was not found to be pervasive, practitioners in their sample were aware of neglect and abuse of the elderly and other vulnerable adults. The questionnaire is included in the report.[10]

Incidence of Various Forms of Abuse

In The Battered Elder Syndrome: An Exploratory Study, psychological abuse is reported to be more common than physical abuse, particularly if other categories such as "lack of care" are included. Types of abuse, by frequency were:

- Physical -- no apparent abuse, 15%; bruises and welts, 31%; sprains and dislocations, 4%; malnutrition, 4%; freezing, 4%; abrasions and lacerations, 8%; wounds, cuts, and punctures, 4%; bone fractures, 8%; skull fractures, 4%; beatings, 15%; lack of personal care, 38%; lack of food, 19%; lack of supervision, 38%; tied to bed, 8%; and tied to chair, 4%.
- Psychological -- verbal assault, 58%; threat, 46%; fear, 50%; and isolation, 58%.
- Material -- theft of money or property, 12%; and misuse of money or property, 46%.
- Rating of environment -- dirt in house, 38%; vermin in house, 8%; inadequate heat, 4%; smell like urine, 19%; and no food in house, 8%.

Information was also provided on severity of abuse. Prior incidents were reported in 58% of the 26 cases and were unknown in 38%. Block and Sinnott found that most of these abuse cases (95.24%) were reported to some authority, but apparently unsuccessfully, since help was not provided. Most contacts were with social service agencies.[11]

These findings are in contrast to those of the Massachusetts survey and those of Lau and Kosberg. Professionals and paraprofessionals in the

Massachusetts survey cited bruises and/or welts (44% of all citings) as the most frequent injury inflicted on the abused elderly. Subsequent and debilitating mental anguish followed in 40% of all cases. Other types of abuse were recorded less frequently. Thirty-four percent of the injuries involved minor trauma such as bruises, welts, cuts, or punctures, while 7% were major, and included skull or other fractures and dislocations.

"Neglect" was sometimes of a serious nature but frequently was not clarified by respondents. Each abuse citation was classified into one of seven categories. The primary problem was unclear in 33 of the 183 citations. But in 96 cases, some form of battery was involved. Twenty citations reflected primarily verbal harrassment, 16 involved malnutrition, 8 reflected financial mismanagement, such as the withholding of rent and food monies, and 7 involved unreasonable confinement; and there was one case of oversedation and one of sexual abuse.

The data show that one of every five cases was reported to the respondent at least twice. The Massachusetts data indicates that visible injury to the elderly may be present in a large proportion of abuse cases and may serve as a clue in assisting practitioners in the identification of such cases.[12] Lau and Kosberg reported finding that three fourths of 39 identified cases involved physical abuse, and more than half involved psychological abuse. Twenty-nine individuals experienced physical abuse: beatings, 11; lack of personal care, 19; lack of food, 16; lack of medical care, 14; and lack of supervision, 12. Twenty experienced psychological abuse: verbal assault, 13; threat, 4; fear, 7; isolation, 8. Twenty-one suffered material abuse: theft of money or property, 7; and misuse of money or property, 6. Seven experienced violation of rights: forced from home, 5; and forced from nursing home, 5.

In most cases, more than one type of abuse was involved. Only 10, or 26%, of the 39 cases of physical abuse did not involve other forms of mistreatment. Similarly, only 2 of the 20 cases of psychological abuse and 2 of the cases of material abuse occurred in isolation. Violation of rights consistently occurred in conjunction with at least one other form of abuse.[13]

In the Michigan study, respondents frequently cited inadequate diet as a problem. A relatively large number felt that, while the basic dietary needs of the elderly usually were met, those responsible for their care were poorly equipped to handle the responsibility.

Many respondents said that when the needs of the aged were not met, they were treated like children or in a manner which impaired their feelings of self-worth or which was threatening. No major differences were found between types of vulnerable adults. Respondents from all categories saw isolation as a major problem. Of those few who responded to the question of active neglect, forced confinement and isolation and withholding of food and medication were the most frequently mentioned problems.

Few respondents noted extensive experience with serious physical abuse, and this phenomenon was least likely to be discussed extensively. Respondents in virtually all categories noted fairly explicit evidence of physical abuse. Some suspected physical abuse but had no direct evidence to support their suspicions. Passive neglect was considered to occur more often than did active neglect. Active neglect was reported to occur less frequently than was emotional or verbal abuse, and physical abuse was generally considered to be rare.[14]

Characteristics of the Abused Elderly

At this point, it is important to note that the authors of these reports repeatedly refer to the limitations of the studies and the preliminary and exploratory nature of their findings. They warn against drawing conclusions on the basis of their data and stress the need for further research to confirm their findings.

The authors of The Battered Elder Syndrome: An Exploratory Study report that, based on their limited data, the abused elder is older than average, female, Protestant, lower- to middle-class, and living with a relative. No physical impairment was reported for only 4% of the 26 cases of abuse. Mental impairment was reported for 62% of the abuse cases: severe, 12%; moderate, 35%, and mild, 15%. No impairment was reported for 15% of the cases. Twenty-three percent of the cases did not respond.

Lau and Kosberg report that 30 of the 39 abused clients (29 white and 10 black) identified in their study were women. Twelve lived alone, nine with a spouse, seven with a daughter, and ten with another relative. Fifty-one percent of the clients were unable to walk without the assistance of another person or a walker or required a wheelchair. Ten percent had a hearing or visual impairment, 18% were partially or totally incontinent, and 41% were either partially or totally confused or senile. Collectively, more than three fourths had at least one major physical or mental impairment.

The preliminary picture sketched by these findings is that the majority of the abused elderly are female, are in the older elderly age group, are physically and/or mentally impaired, and live in the community with an adult child or some other family member.

Some information is provided on the reactions of the elderly to abuse. Lau and Kosberg, for example, list typical reactions and their frequency:

denial, 13; resignation, 10; withdrawal, 8; fear, 6; depression, 4; protection seeking, 4; mental confusion, 3; anger, 2; and other or unknown, 6. Frequently, denial was found to be related to protection of the abuser, denial of the existence of a problem, or psychological refusal to acknowledge the problem. Resignation was described as a more conscious (and verbalized) acquiescence to abuse, while withdrawal involved psychological acquiescence and passive acceptance.[16]

The authors of the Massachusetts report found that the largest percentage, 36%, of respondents indicated that the refusal of the victim to acknowledge the problem constituted the primary barrier to service. Refusal was variously attributed to "fear of retaliation" by the abuser, feelings of kinship and love for the abuser, or simply as a refusal to accept services.[17]

Respondents to the Michigan study frequently found that abused individuals were fearful of reprisals from the abusers if they reported problems to authorities. Such reprisals could take the form of heightened abuse or withholding of attention, shelter, or visitation. The respondents occasionally characterized the abused as being too apathetic or too independent to seek help.[18]

Characteristics of the Abusers

The Battered Elder Syndrome: An Exploratory Study reports abusers to be relatives of the victim in 81% of the cases. Females (58%) more often than males are the abusers. Forty-two percent were sons or daughters (in-laws included), 15% spouses, 19% grandchildren, 4% other relatives, and 19% unrelated caretakers. The majority of the abusers were middle-aged (40s and 50s); 65% were middle class, 12% lower income, and 4% unknown. The religious identification was Protestant for 35%, Catholic for 8%, Jewish for 4%, and unknown for 53%. The race was white for 88% and black for 12%.[19]

The abuser lived with the victim in 75% (137) of the cases of abuse cited in the Massachusetts survey and was a relative in 86% of the cases. Sons, husbands, and daughters were the most frequent abusers, 24%, 20%, and 15%, respectively. Only 14% of the abusers were unrelated to the victims. More than one person inflicted the abuse in about one in every ten cases.

Twenty-eight percent of the abuses cited in the Massachusetts survey indicated that the abuser was suffering from either alcoholism or drug addiction at the time of the abusive act. Long-term medical complaints (18% of the abuse cases) and long-term financial problems (16%) were primary categories of stress noted by respondents. The frequency with which each stress category was checked is considered to be less significant than the presence of stress in 74% of the abuse citings. The researchers note that the relative ranking of stressful conditions remains unclear, but the stress itself appears to be a potential factor in the abusive situation.

In 116 (63%) of the Massachusetts responses citing abuse, the elderly victim was identified as a source of stress to the abuser. In 48% of the these surveys the elderly victim's need for a high level of physical and emotional care from the abuser was the source of stress. Financial dependence on the abuser or severe physically debilitating conditions were the source of stress for the abuser in 13% of the cases.

In 75% of the responses citing abuse, the elderly victim was described as having a mental or physical handicap which impaired daily functioning; this suggests that the impairment of the elderly victim and its effect upon the abuser may be a relevant variable for further analysis. Nagging, demanding, manipulative behavior; previous family history of arguments over specific issues, and arguments over the placement or the services for the elderly were recorded as the victim's contributions to the stress of the abuser.[20]

In discussing the abuser, Lau and Kosberg identify 13 as the daughters and 6 as the sons of clients. In 6 cases the granddaughter was the abuser; in 5, the husband; and in another 5, a sibling (generally a sister) was at fault. In 4 instances, the abuser was a non-relative. In 2 cases, the abusers were a son and a daughter and in another 2, a daughter and a granddaughter.[21]

Characteristics of Professional and Paraprofessional Respondents

Among professional groups contacted under Plan B of The Battered Elder Syndrome: An Exploratory Study, social workers were found to report the largest number of cases, with 43.75% citing abuse of the elderly. Block and Sinnott suggest that this group might be systematically oversampled in the future.

On the other hand, only 25% of the psychologist/counselor group reported cases of abuse of the elderly, far fewer than might have been expected given their numbers. Among administrators, 25% reported abuse cases, and the abuse report ratio for registered nurses was 6.25%. Professionals who reported cases tended to have either less than 10 or more than 20 years of experience and were more likely to be serving a geriatric client population.[22]

The data in the Massachusetts survey of professionals and paraprofessionals show that elder abuse was cited by all but one of the professional/paraprofessional categories surveyed -- public welfare protective services managers.

Visiting nurses, hospital social service directors, and private social service agency staffs were responsible for 109 of the 187 citings of abuse, but the researchers remind the reader that these professionals received 47% of the questionnaires.

Some groups had a much higher response rate than others. Home care corporation staffs, for example, received 28 questionnaires, returned 22, and reported 20 cases of abuse. This is a much higher response and citation rate than in any other profession, although the absolute number of abuses reported is less for home care corporations than for some other professions. High response and citation rates were also found in the professional category labelled "other." These included a small number of health-oriented professionals (e.g., nurses and medical social workers), probation officers, and others who primarily provide services to the elderly.

Visiting nurses, hospital social service directors, and home health aide staffs also showed relatively high response rates -- 63%, 34%, and 34%, respectively. And as professional groups, these reported fairly large numbers of abuses relative to the population surveyed. Such data would indicate, according to the researchers, that in future studies these professions should play a crucial role as sources of research data and as the professionals most likely to see and deal with abuse.

Emergency room nursing supervisors, police, and welfare protective service managers at the regional level reported the fewest cases of abuse, despite a reasonable expectation that these professions would have knowledge of elder abuse cases through their roles as mediators of family violence. The logical next question is why these key professions report such a limited number of cases. In no instance were all members of a profession surveyed; in some cases only agency directors received questionnaires and in others a self-selected and non-respresentative segment of the profession was surveyed. Additional research will be required in order to determine more accurately the relative involvement of each profession in abuse reporting.[23]

In the Lau and Kosberg study, 87% of the abused clients were living at home at the time of referral to the Chronic Illness Center; the remaining 13% were already hospitalized. Eleven social workers, as well as public health and visiting nurses, were involved in referring the home-based aged. In the majority of cases the problem was health-oriented. It was only after intervention by CIC staff that a determination of abuse was made. Non-health-related reasons for referrals included reports of filthy homes, poor diet, and lack of attention to personal hygiene and grooming.[24]

In the Michigan study, 10 analytic categories, in both the public and private sectors, were represented in the study sample -- police, physicians, nurses/aides, caseworkers, adult service workers, mental health counselors, services to the aging personnel (mostly involved in outreach efforts and lawyers), clergy, morticians, and coroners. The respondents were essentially mid-career, well-educated, equally balanced between male and female, and involved in their current work roles sufficiently long enough to be familiar with the community they serve and to have gained a variety of experiences in their roles.

Only the mental health practitioners, as might be expected, were primarily involved with non-elderly adults -- the emotionally impaired. The fact that maltreatment of the elderly was only a hypothetical concern for some respondents should not be taken as an indication of limited experience with the elderly, according to the authors. Many respondents serve the general population to a greater extent than any of the four special categories of adults, and some work with the most independent, mobile, and healthy aged, providing services in the community which are often social in nature.

Respondents among nurses, caseworkers, and aging services practitioners in the Michigan study reported verbal and emotional abuse in terms of

overprotection and denial of the need to be independent. Caseworkers were most likely to focus on the caretaker as the principal figure in emotional abuse and to describe this individual as frustrated, overwhelmed, tired, stressed, or overburdened. Caseworkers and aging services practitioners also brought up the issues of the insensitivity of professionals and the contributions of agencies to the problems of the verbally or emotionally abused.

When the general condition of the elderly was discussed, caseworkers, physicians, adult service workers, and lawyers in particular noted that, when their needs were not met, the elderly were treated like children or in a manner that impaired their feelings of self-worth or was threatening.

Physicians, morticians, and medical examiners occasionally noted the presence of physcial marks and bruises which strongly suggested some kind of physical violence that did not appear to have come from a single episode or a fall. Visiting nurses, caseworkers, mental health counselors, and police officers were more likely to cite cases in which the victim reported that he or she had been physically injured at home but was unwilling to provide details for fear of retaliation.[25]

Intervention Efforts

Block and Sinnott, writing in The Battered Elder Syndrome: An Exploratory Study, indicate, as was noted previously, that 95.24% of the 26 cases of abuse were reported to some authority. These abused elders were unable to find help. Anecdotal accounts suggest that the abused felt trapped in their situations.[26]

Most of the 183 responses citing abuse in the Massachusetts study indicated that more than one type of intervention action had been taken or had

been attempted. In 62% of the citings some form of direct action was taken. Emergency action was taken in 22% of the citings, and a referral was made in 48%.

Placement in a nursing home, a hospital, or a temporary housing or mental health facility was the single direct action most often taken or recommended (36%). Arrangements for in-home services (homemakers, chore services, meals on wheels, visiting nurses, or home health aides) constituted 22% of all direct action. Coordination of interagency treatment plans (16%), counseling or talking to the abuser (15%), and talking with the abused individual (13%) were other forms of direct action.

Fifty-six percent of all "emergency action" included removal or recommended removal of the victim from the home. Included among reasons for removal were medical treatment in a hospital emergency room or hospitalization (39% of all emergency action), nursing home placement (5%), or other placement, such as public housing (12%). Other types of emergency action included calling the police or a crisis or support team and arranging for the household to be monitored.

Referral to social service agencies was the most frequently checked category (48%). The agencies identified included mental health clinic staffs, home care corporations, hospital social services, family service agencies, visiting nurses, and public welfare. Legal services represented 20% of all referrals. Five percent of the referrals were made to the police.

The data indicate a wide variety of responses on the part of the professionals. Referral to social service agencies, counseling, arrangements for in-home services, and removal of the victim appear to be the most frequently employed intervention strategies. The range of responses also suggests a wide disparity in skills, approaches, and attitudes among

respondents. At one end of the continuum, a respondent confronted an abuser, directing the individual to stop abusing the victim. At the other end, respondents called in crisis teams to evaluate the victim and to establish interdisciplinary treatment plans for the victim, the abuser, and the family. The question that arises is whether this wide range of responses to abuse is because of the variables at work in the abuse case itself or the skill and services available to the professionals dealing with the cases.

A second interesting finding is the degree to which placement is cited as a response to abuse. In some instances, respondents noted their frustration in locating suitable alternatives to hospitals and nursing homes as places of refuge or respite for the victim.

Of the 183 citings of abuse in the Massachusetts survey, 129 (70%) indicated that some barrier to service provision was experienced by workers. Forty-eight respondents failed to answer the question, and four surveys noted that no barriers existed. As was indicated earlier in this paper, 36% of the surveys reporting barriers indicated that the barrier was the victim's refusal to acknowledge the existence of a problem.

Fourteen percent of the surveys identified legal problems as the barrier; these problems include the lack of legal protection for workers who intervened, no eyewitnesses to the abusive act when the victim refuses to file a complaint, the lack of an appropriate person to accept guardianship for the victim, the requirement of a formal complaint from the abused individual before police can take serious action, the unwillingness of witnesses to testify, and the lack of formalized statutes protecting the elderly from manipulation/exploitation.

The lack of cooperation on the part of the abuser and/or family with whom the elder resided was the principal barrier to service provision cited in 13%

of the responses. Eleven percent reported the lack of services or the lack of coordination among service providers. The identified services which were unavailable included protective care for adults, respite care facilities, temporary shelters which can care for persons requiring assistance in activities of daily living, emergency foster care for the elderly, and nursing home placements. In 9% of the responses the worker was barred from entering the home by the abuser or the family. Three percent reported agency attitudes to be a service barrier.[27]

The Chronic Illness Center (CIC), site of Lau and Kosberg's exploratory study, categorized the outcomes of professional intervention in cases of abuse into three areas: institutionalization, unresolved problems, and assistance provided and utilized. Eighteen of the 39 elderly persons were eventually placed in nursing homes. The authors point out that all clients served by the CIC suffer from some type of physical or mental health problem and that institutionalization might have been appropriate even without the existence of abuse. Yet, a health problem in combination with an unsatisfactory living arrangement and/or abuse might increase the need for agency staff or family members to seek institutionalization for the client.

Assistance and intervention were refused in 10 CIC cases. In some instances family members (often the abusers) refused to allow CIC staff or the community representatives to talk to the older person or otherwise to provide assistance. Legal action was threatened in one instance. Often denial of the problem by the abused and abuser precluded professional intervention. Although a problem was acknowledged in some cases, both the elderly individual and the relative(s) indicated that the problem and the solution would remain a personal family matter. In 11 cases, professional assistance was offered and accepted. Assistance from the CIC and referrals to other agencies led to

resources such as nutrition programs, recreational activities, homemaker services, guardianship, dietary counseling, placement in a different setting in the community, live-in-help, counseling, and legal assistance. Such professional intervention made it possible to focus on the root of the problem in some instances and to separate the abused from the abusing person in others.[28]

Sixty-five percent of the 220 coded responses in the Michigan pilot study indicated verification of neglect and abuse by personal observation and/or a home visit. The least frequent source of verification (9%) was to talk to friends and neighbors of the victim. The remaining 68 respondents reported that they contacted caretakers or family members or that they made a referral to other agencies or professional groups. Eighty-nine of 153 coded responses indicated that little would be done in the way of long-term follow-up. Forty-four respondents reported that an attempt at follow-up would be made. Twenty respondents reported a plan for regular and frequent follow-up. Only 34.6% of those responding stated that their agencies had an established policy for disposition of cases of neglect and abuse of adults. Of this group, 31.0% indicated that this was a written policy.[29]

VIOLENCE IN AMERICA AND IN THE AMERICAN FAMILY

In focusing on violence in America and in the American family, it is appropriate to discuss a recent study, Behind Closed Doors: Violence in the American Family, and its implications for parent abuse.[30] The book reports on the results of the first comprehensive national study of violence in American homes. The intention was to answer a number of fundamental and important questions about family violence. Study goals were to measure the extent of violence in the American family, to uncover the breadth of family

violence, to determine what violence meant to the participants, and to assess what caused the violence to occur. The objective was to point the way to solutions for preventing family violence by identifying some of the generative sources of violence between family members. The study's stated intention, goals, and objective make it pertinent to this paper's discussion, although "parent abuse" was not examined. Careful consideration was given to the relationship between child abuse and spouse abuse in an effort to deal with violence in the family as a whole. This effort is recognized as limited, because of the exclusion of certain areas of family violence, for example, violence by children against their parents and "verbal violence."

America has long been known as a violent society, according to authors Straus, Gelles, and Steinmetz, but they record their surprise at learning that the American family and home are possibly more violent than any other single American institution or setting -- except for the military in time of war. Due to the lack of prior systematic studies of violence in American families, no definitive statement as to whether violence in the American family is on the increase is possible. Historical facts are said to argue that family violence is not new and that there is no more, and possibly slightly less, violence among the families of today.

America's tradition of physical and emotional cruelty to children is noted. The society justifies this cruelty through religious dogma or by claiming that it is in the best interest of the child. This societal mandate and tolerance of physical violence toward children is suggested as a possible factor in delaying the identification of child abuse as a significant social problem. By the end of the 1960's, all 50 states had passed and instituted laws mandating the reporting of child abuse and neglect and had begun to initiate action to treat abused children and their families. Americans have

probably abused their children since colonial times, but it is only in the last 20 years that the issue of abuse has received serious attention.

There is also no evidence which can be used to estimate the incidence of "wife abuse" in America over the last 300 years. Yet, historical and legal data are available which demonstrate that women have been subjected to brutal and often lethal forms of violence in their own homes. It was not until after the mid-1970's that wife abuse received national recognition as a social problem. By 1980 the issue of battered wives reached the status that child abuse had achieved in 1968. Laws are being written and rewritten, and experiments with prevention and treatment programs are being initiated. However, as with child abuse, information on how many wives are abused, what causes them to be abused, and what can be done to protect and treat victims continues to be inadequate.

Behind Closed Doors: Violence in the American Family points out that violence toward women and children is now a priority social problem because of political and social action. Readers are instructed not to let the "politics of social problems" misdirect them into thinking that there are no other forms of family violence. The study also examines sibling violence and abuse of husbands. The authors maintain that child and wife abuse are major concerns (as is the issue of parent abuse in this paper), but the larger problem is not one of a single class of people, sex, or age group in the family being the most victimized. The historical and statistical data support the claim that the problem is one of family violence. Parents hitting children and each other and siblings hitting one another are all part of the same issue, violence in the American family. And, the abused parent is also part of this issue.

The final study sample yielded 2143 completed interviews with families representative of the approximately 46 million families in the United States in 1976. Interviews were conducted with one adult family member (960 men and 1183 women) who ranged in age from 18 to 65 years. Of the 2143 families studied, 1146 had children between the ages of 3 and 17 living at home. The violent acts reported as necessary by parents, siblings, and spouses would have been considered chargeable assault if perpetrated outside the home.

Almost 1 of every 8 couples is reported to have admitted to an act of violence capable of causing serious injury at some point in their marriage. For the first time, there was reliable scientific data on a nationally epresentative sample. This data showed that violence toward children extends far beyond ordinary physical punishment. Many children periodically experience severe beatings, kicks, and punches in their homes. The actual percentage of parents who physically abuse their children is small. Yet, when the figures are extrapolated to the national population, it becomes evident that millions of children are involved.

Concern has been expressed regarding violence in television. But, the authors question the consequences of children seeing or being victims of violence in their own homes. Conventional theory maintains that the more violence a child views on television, the more she or he tends to be violent, or to tolerate violence. If this is so, the next question is what are the consequences of millions of children being the victims of violence and watching their parents use violence. Although television and movie violence probably make some contribution to violence in the streets, schools and family and to assasinations and murders, the authors indicate that the evidence seems to support the notion that American homes are the primary generators of this violent society.

The statistics are said to repeatedly suggest the same conclusion: "each generation learns to be violent by being a participant in a violent family."[31] The study traced this learning process through three generations. It was found that the more violent the grandparents, the more violent the couples in the study are as husbands and wives and the more abusive they are to their children. The research question that arises in the context of a discussion of parent abuse is whether these violent grandparents, in turn, become the victims of abuse when they become the aged and vulnerable family member. The study found that the children of violent couples tended to follow the behavioral patterns of their parents. To sum up, "violence begets violence," and not only against the people who abuse but against others (siblings, husbands, and wives).

Some of the learning about violence in the family occurs by example; i.e., children see their parents hitting each other. Some of the learning occurs as a result of being the victim of violence. The more children are hit by their parents, the more likely they are to hit others. Yet, it is pointed out that it would be a mistake to place the entire burden of violence on what is learned in the family. Violence on the part of people whose parents are not particularly violent to them and not violent to each other does occur. However, these rates are a fraction of the rates for those who come from violent homes. The family may be the main training ground for violence, but in this violent society, this role is shared with others.

The authors devote a chapter to an examination of whether social factors make a difference in a family's inclination toward violent behavior. Age, income, and full-time, part-time, or no employment are reported to have a strong bearing on family violence. To a lesser extent, religion, residence in a city or in the country, region of the country, and race also were related to

violence in the home. The researchers record their surprise at learning that the uneducated were not the most violent. They found some factors to be more strongly related to specific types of family violence.

This national survey of family violence cannot be used to rule out the theory that personal factors are related to violent behavior. On the basis of their finding that social factors are related to violence, the researchers maintain that personal counseling will never be sufficient for the treatment or the prevention of violence in the home. Stress is proposed as a major contributor to family violence, a factor also suggested by the preliminary findings of the studies reviewed in this paper.

Most social agencies and their staffs are said to tend to view a child-abusing parent, a wife-beating husband, or a child who kills a brother or a sister as mentally ill. The most frequently discussed and implemented solution is individual psychiatric care or marriage counseling for the violent person. Psychiatry or other psychological therapy is identified as clearly needed in only about 10% of the cases. Since the roots of family violence are to be found in the family itself, the authors suggest that what is needed for the most part is a restructuring of the relations between family members.

The Battered Elder Syndrome: An Exploratory Study also devotes attention to the antecedents and consequences of intrafamily violence in the United States. The socialization processes which allow the development and sanction of variant forms of violent behavior are examined. Again it is indicated that incidents of child, spouse, and parent abuse demonstrate that violence is prevalent within American society. Physical force exists as a continuing element in family social interaction. In an attempt to better understand the underlying factors and motivations related to violence in the family, the study focused on the following: 1) aggression from a social-learning

perspective and society's attitude toward aggression, 2) prevalent myths concerning societal aggression, 3) the correlation of situational and environmental factors with aggression, 4) the characteristics of anti-violent communities, and 5) possible interventions.

Social-learning theory views violent behavior as a learned response which is reinforced by situational stimuli. This is contrary to the tenets of biological drive theories, which identify aggression as an inborn tendency which needs to be released periodically in order to avoid larger outbursts. In discussing society's attitude toward aggression, the chapter's author, Sedge, concentrates on current American childbearing practices and the influence of the mass media, and the violence therein, upon the socialization process of the child. Through the process of social learning, the individual acquires society's positive attitude toward agression.

Mention was made in Behind Closed Doors: Violence in the American Family that Americans typically punish their children by physical means. They approve of physical punishment administered by teachers, despite laws prohibiting corporal punishment. In this respect, the culture may provide aggressive models at home and at school which facilitate aggression in American society. Cross-cultural studies are reported to demonstrate that physically violent societies produce aggressive and violent children who, in turn, become violent adults.

Sedge suggests that myths provide easy explanations of and convenient justifications for violence and aggression. Myths can reinforce the modeling of such behavior in child-rearing practices and in the mass media. Four myths concerning violence are identified as important to the discussion: aggression

occurs within the lower class; aggression occurs only among racial minority groups; catharsis is an effective model to reduce aggression, and individuals are innately aggressive.

The Battered Elder Syndrome: An Exploratory Study deals with other factors considered to be associated with violence. These include unemployment or the lack of resources; unsatisfactory employment conditions; factors which diminish inhibitions against aggression such as alcohol, familiar environment, presence of friends and relatives, denial and rationalization, and positive reinforcement by compliance; male dominance societal norms; and environmental conditions such as density of children and residential crowding.[32]

In subsequent chapters, the focus turns to specific forms of family violence -- child, spouse, and elder abuse. The literature relating to these forms of family violence is reviewed within the context of the more general discussion of violence in the American society and family.

The Massachusetts demonstration project, conducted by Legal Research and Services for the Elderly, reviews the literature on violence in the family and elder abuse. The Michigan pilot study reviews literature for the purpose of developing a theoretical framework for the etiology of domestic violence. The result is the availability of extensive bibliographies on the subject of abuse/violence in the American family in three of the four studies reviewed in this paper and in Behind Closed Doors: Violence in the American Family.

POTENTIAL CAUSES OF ABUSE

The preliminary findings of the four research studies reviewed suggest some potential causes of abuse. The majority of the abused elderly were unable to care for themselves. The abuser was described as experiencing some form of stress, e.g., alcohol or drug addiction or medical or financial

problems. In some instances the elderly victims and the care they required were the identified source of stress.

As the preceding discussion of violence in the American family suggests, a potential cause of abuse in the observation that "violence begets violence." The abuser may reverse earlier behavior and abuse the parents or caregivers who mistreated him/her earlier in life. The violence continues from generation to generation as the normative response to stress in the family.

In the literature review by Legal Research and Services for the Elderly in Massachusetts, note is made of this society's myth that older individuals are abandoned by their children; 75% of the elderly live with these children or live 30 minutes away. Eighty percent of home care to the aged (55 and older) is provided by family members living in the same household. The middle-aged adult of today is more likely to have a living parent than his/her counterpart in the past. This likelihood increases each year due to the fact that the elderly population is increasing proportionally to the total population.

This suggests that adult children or other family members may be the providers of a significant amount of care to an increasingly larger and older elderly population. The chances are increasing that everyone may at some time be caring for one of his/her parents. The possibility that the parent will be both quite old and possibly quite frail is also increasing. The question that then arises is what effect these various demands will have on the financial and emotional resources of the family.[33]

Davidson, in The Battered Elder Syndrome: An Exploratory Study, prefaces discussion of potential causes of abuse with the comment that "possible causes can only be described as ones creating the potential for violence." Further

research is identified as necessary for determining how the various factors interact to create a situation of abuse.

Economic and population changes are listed as potential causes, for they can significantly affect the caretaking abilities of adult children. Medical costs are increasing. The older population is increasing. More people live past age 65, thus increasing the demand for alternative living arrangements. Service availability is inadequate for families who need support in their care of an elderly parent.

A change in the older person's life may create the potential for abuse. The elderly individual may not be as comfortable or feel as free as anticipated. Consequently, the sense of control over his or her own life may decrease, and the sense of dependency increases. And there may be increasing physical and mental impairment.

The adult offspring may also experience life changes, e.g., retirement and the expectation of a freer and more relaxed life style. The number of middle-aged women returning to work continues to increase, reducing the time and affecting their willingness to care for an elderly relative.

Factors in the family relationship may create the possibility for abuse. Only one adult child may be responsible for the care of the parent and may begin to view this responsiblity as a never-ending burden. Caregiving responsibilities may create a situation of conflict for married, middle-aged women who are trying to care for their husbands and children while meeting the needs of parents and parents-in-law. Situations where the caretakers themselves are senile and elderly may lead to abuse. The inability to see the parent in any way other than in the parent role can create conflict as the dependency of the older parent increases. If an adult offspring is able to accomplish the task of filial maturity in his/her 40's and 50's, he/she can

become a dependable resource for the older parent without taking on a parental role. Conflict between older spouses may lead to one battering the other. Finally, unresolved conflicts between parent and adult offspring may be a potential cause of abuse.

The decision to have an aging parent live in the adult offspring's home may be made too hurriedly at a time when family emotions run high and may create the atmosphere for potential abuse. The possibility that the parent might continue to live independently may not have been fully explored.[34]

Steinmetz notes several parallels between the battered child and the abused parent who is residing with an adult offspring. Both depend on the caretaker for basic survival needs, both reside in a family setting that is assumed to give love and caring protection, and both can be a source of emotional, physical, and financial stress to the caretaker.[35]

Davidson, Hennessey, and Sedge state that there has been no research to determine the possible relationship between abuse of the elderly by family members and ageism, attitudes toward the disabled, disability perceptions by older individuals, and learned helplessness. These factors are dealt with in the effort to provide background information and discussion relevant to the development of theories and further research concerning abused elderly. The authors conclude that individual perceptions and attitudes of the older person and his/her family and societal prejudices are factors that may act as causes or catalysts for abuse. It is recommended that these factors be considered in the development of theory and research design concerning abuse and in education and treatment programs for persons directly involved in abuses against the elderly.[36]

INTERVENTION

In discussing practitioner intervention, the focus will be on the issues that emerge in the context of legal, social, and preventive intervention and public policy formulation.

Legal Intervention

In a chapter entitled "Proposed Mandatory Reporting Law" (The Battered Elder Syndrome: An Exploratory Study), Block and Davidson describe elements of special consideration in the development of such a law. They recommend language for these legislative elements and provide modifying comments concerning the intent of particular elements. The elements are the purpose of the law, a definition of age, a definition of abuse, guidelines for reportable abuse, persons responsible for reporting abuse, the method of reporting, the agency receiving the report, the mandate to the receiving agency, immunity, the waiver, the penalty clause, the central registry, and protective services.

Block and Davidson maintain that in order to identify the number of elder abuse cases now hidden from public view, passage of state mandatory reporting laws (MRL), similar to those utilized in child abuse cases, is essential. The objective of a reporting law would be to identify abused elders so that they would receive treatment for injuries and protection from further abuse. It is indicated that the need of the elderly individual for assistance would not restrict personal and civil rights.

The protective services element of a mandatory reporting law would cover supportive services to persons in need, with their consent or under legally enforced supervision or guardianship. The latter provision allows an agency or an individual to assist the older person without his/her consent. In commenting on this element of the law, the authors write that the core of

protective services is the visits of a social worker, supplemented by various community services.

Protective services differ from other social services in that the potential for legal intervention is a part of the program. Guardianship, institutional commitment, emergency services, and protective placement are all forms of legal intervention.[37]

The remainder of this discussion is based on the Legal Research and Service for the Elderly report "Legal Analysis." The report analyzes Massachusetts state laws in terms of its provision of remedies for abuse victims. It also summarizes and analyzes a survey of abuse reporting and protective laws which have been adopted across the United States. Focus was on the issues raised by abuse reporting and protective service laws, rather than on a state-by-state analysis of the statutes.

Potential abuse clients include both those who are willing and anxious to pursue, on their own initiative, service provision or a legal remedy and those who cannot or do not seek assistance and who enter the system via intervention procedures. The first type of client can seek recourse through the jurisdiction's criminal and civil machinery. Some form of state intervention may be an alternative when a client is neither willing nor able to act in his/her own behalf. The individual's capacity to make the necessary decisions is the primary consideration in such a case.

The state of the law in Massachusetts is discussed in terms of the criminal remedy, civil relief in the form of an Abuse Prevention Act, and protective services (access, confidentiality, and available alternatives).

Abuse of an elderly individual is a criminal violation of the law. Yet, the question of whether reliance on the criminal process is a valid alternative arises. The exercise of criminal sanctions -- deterrence and

punishment -- requires the elderly individual to file a complaint and to testify in court. In many cases the elderly individual would never consider such an action. There may be no desire to deter the abuser through a possible jail sentence.

For criminal prosecution there must be evidence of abuse beyond a reasonable doubt, and such evidence is difficult to obtain for acts committed in the home. Prosecution will not change the fundamental cause of the abusive behavior, and unsuccessful prosecution may mean increased risk for the elderly victim. The criminal justice system functions in isolation from service provisions. Consequently, it cannot correct the underlying causes of the abuse and does not provide the essential protection and support services.

In July 1979 the Massachusetts legislature passed an Abuse Prevention Act. This civil remedy was designed to prevent physical abuse among family and household members and to alter significantly the responsibilities and powers of police officers. The statute's provisions establish procedures to obtain protective orders for victims of abuse and require the police to take specific action to enforce those orders and to prevent further abuse.

The law has developed, pursuant to parens patriae (authority granted to the state to act in a parental capacity for those individuals who cannot care for or who are dangerous to themselves), a procedure by which the state assumes surrogate authority for an individual. The alternatives, as both the law and the social service area reflect, are known as protective services.

Among social service workers, the question of access to persons living in private residence in order to perform outreach or to offer services is frequently a key issue. Massachusetts law provides no legal authority under which a social service worker can gain access without the consent of the elderly person or the caretaker. Because this legal constraint often creates

difficulty in outreach and service provision efforts, some social workers resort to access through homemakers, housing inspectors, or meal providers. Although good intentions are the basis for this intervention, deception is employed, confidentiality is betrayed, and the action is inappropriate. At the same time, such action creates the potential of civil liability for the worker and his/her agency.

The concept of "best interests" of the client cannot be used to rationalize this disregard of rights fundamental to the legal system. It is possible that the violations occur because there are few reasonable and viable alternatives in the State of Massachusetts for dealing with the problems of the elderly person.

Recent legislation in 24 states establishes civil remedies and injunctive relief for victims of domestic abuse. Seventeen of the states have laws which cover spouses, cohabitants, and/or relatives by affinity or consanguinity. Because abusers of the elderly are more often family members, these laws offer injunctive relief to the abused. The statutory provisions vary from jurisdiction to jurisdiction, but a majority include the issuance of protective and vacate orders upon petition by the victim. These laws can be useful and potentially effective legal tools of protection. Yet the statutes, with limitations similar to those of the Massachusetts law, afford even less protection because of weak enforcement provisions.

The Massachusetts survey of professionals and paraprofessionals found that in a large proportion of abuse cases the barrier to service provision was the refusal of the victim to acknowledge the problem or to take action. Many workers questioned the lack of legal authority to intervene in domestic cases.

Exercise of the parens patriae power has traditionally been marked by an atmosphere of informality. The justification for these informal procedures

has been the impression that the court's determination was to be based solely on the "best interest" of the individual, thereby eliminating the need for an adversarial process. This reasoning, although still adhered to, conflicts with reality.

The exercise of parens patriae often involves serious limitations on individual rights in the form of involuntary placement or institutionalization. Traditionally, the procedure followed for persons determined to be legally incompetent or unable to care for themselves has been civil commitment, guardianship, and conservatorship. These laws have been criticized for being outdated and possibly unconstitutional. State laws pertaining to long-term protective care have rarely provided for anything short of these alternatives.

Some states have adopted specific legislation, including abuse reporting laws and protective services laws as distinct from guardianship proceedings, in an attempt to provide procedures and remedies for incapacitated adults who are abused, neglected, and exploited. This legislation provides the mandate to allow for access by social service workers to investigate for abuse, neglect, or exploitation; to require reporting of abuse, neglect, or exploitation with immunity and confidentiality guaranteed; to affix penalties for violations; and to allow for voluntary and involuntary provisions of protective services while safeguarding individual rights against inappropriate intervention.

Approximately 11 states have adopted some form of an abuse reporting law and protective services laws. Four have statutes which provide a mandate for protective services systems without reporting, access, or involuntary service provisions. Two states have adopted protective service legislation which includes involuntary service provisions but no mandatory reporting and investigation provision.

The critical provisions of an abuse reporting and protective services law are those which determine and define how the conflict between individual rights and state intervention is resolved. These provisions primarily concern the definition of persons covered by the law, the standards for reporting and investigation as they affect rights of privacy and confidentiality, the right of access to private homes to investigate and to provide services, and the due process safeguards in the determination and provision of involuntary services. An important issue is whether such laws are linked with service provision systems that are capable of meeting the needs of individuals under the purview of the law. Payment procedures for these services are the cause of administrative and legal problems.

The authors of "Legal Analysis" consider the existing statutes and remedies essentially to be inadequate. The statutes are predicated on the importance of utilizing the least restrictive alternative in treatment and placement. But there is insufficient funding and development of such programs and alternatives to realize this premise. The legal remedies and intervention procedures do not always include service provisions which protect the individual's welfare and constitutional rights. Often there is reliance on inappropriate intervention procedures in blatant violation of constitutional standards. The system's desire to do what is "best" for the client and the realities of abuse are responsible for this inappropriate intervention.

It is suggested that the legislation reviewed can be useful and effective in granting protection and services or alternatives in abusive and exploitive situations. Utilization of the laws, however, cannot obscure the necessity for developing social service networks to deal with the underlying problems of abuse and for recognizing the rights of the elderly to choose their own way of life.[38]

Social Intervention

The problems of abused elderly are complex and require a multifaceted approach to solutions. The point is made in The Battered Elder Syndrome: An Exploratory Study that the primary decisions relating to an abuse case are of a social service rather than of a legal nature. Although consultation with the civil or criminal courts is provided for, the goals of intervention are to end abuse and to assure the well-being of the abused and the abuser, as far as possible, and not to prosecute the abuser.

The worker's first decision when investigating a reported case of abuse is to determine whether intervention is necessary. If abuse is suspected following the investigation, it must be decided whether social or legal intervention is the most appropriate approach.

The most common social intervention is identified as removal from the home to an institution. This is considered the least favorable response, for it may deprive the older person of positive relationships at the same time that it eliminates abuse. Additionally, the individual may feel that his/her rights have been violated.

Factors that deserve attention in the disposition of the case and the final determination that abuse has occurred or that the abuser has committed a crime are discussed. One such factor is dependency on the part of the elder. A dependent victim may need a protective placement in order to end the abuse threat quickly. A more independent older individual might be helped by removal of the abuser.

The authors note that, although strategies for intervention depend greatly on the social service system, there is concern because the majority of reported cases analyzed in The Battered Elder Syndrome: An Exploratory Study

approached social services for help with little result. They suggest that changes may be needed in the mechanisms by which abuse cases are dealt with. Revisions in abuse law and reporting procedures may increase the effectiveness of social service agencies.[39]

The "Service Systems Analysis" report, prepared by Legal Research and Services for the Elderly of Massachusetts, initially focuses on two contributing factors to the problems inherent in handling a case of alleged or actual elder abuse. First, more elderly persons live to a very old age and are cared for either partially or totally by family members. A caseworker dealing with alleged or actual abuse must be able to fill service gaps resulting from temporary or permanent disruption of the family support network. Such action calls for a degree of service coordination which is unavailable in many areas. The second factor is the coordination of community services. This difficult task is complicated by the legal and ethical questions confronting the caseworker in instances of alleged or actual abuse and by the possible emergency nature of the case.

Caseworkers asked questions about the following: 1) How to proceed in a situation where concern for the client's safety has to be weighed in a matter of hours against the right to privacy and self-determination? 2) Who has the authority or the responsibility to intervene in such cases? And, 3) how can the necessary community resources be mobilized in such a short time? In an effort to answer these questions, the staff of Legal Research and Services for the Elderly conducted field interviews with persons currently managing elder abuse cases and with national experts, reviewed the literature and statutes, and examined current approaches to children's protective services in the United States.

The multidimensional problem of family violence requires a solution that is multidimensional in scope. Those intervening must be able to respond to the social, legal, financial, emotional, and medical needs of the abused individual as well as to possible housing and nutritional needs. There must be coordination of a variety of service providers and development of service alternatives which currently do not exist in most communities. This interagency, multiprofessional response to abuse of the elderly is crucial to its resolution. Equally important is the need to identify and address the chronic conditions which may have contributed to the elder abuse. Service provisions which focus only on the fact of abuse and not on the contributing factors may serve to exacerbate existing tensions within a deteriorating family system. Services to the abused person's family (or non-related caretaker in the community) is as important a service to the victim in any protective situation as services to the abused.

The legal analysis clearly emphasized the need to accompany a mandatory elder abuse reporting law with a protective services capacity 1) to provide immediate protection to the victim, 2) to coordinate more long-range responses to the chronic conditions underlying the violent act, and 3) to provide current data on the nature of abuse.

Two principles are applicable to the proposed model protective service system for abused elders. These principles -- the client's right to self-determination and the least restrictive alternatives to care -- are implicit. Two additional principles play an important role in the model: maintenance of the family support network whenever possible and use of community-based service alternatives rather than institutionalization of the victim whenever possible -- a derivatitve of the "least restrictive alternatives" principle.

A model, based upon experience and analysis of existing protective services approaches, is proposed. It includes guidelines that must be adhered to in order to establish an effective response to the problem of elder asbuse. The model works as an outline. It offers a flexible framework which communities and the states can employ to establish protective service systems. The model also provides a basis for assessing the effectiveness of existing care networks.

The model consists of general system characteristics which any community should keep in mind when establishing adult protective service systems: a listing of core services which are essential to any protective service system serving the elderly, a listing of additional and important support services which are largely unavailable in most communities, and a delineation of those tasks which could most efficiently be undertaken on a statewide rather than on a community level (standardized record keeping, uniform eligibility guidelines, uniform system of casefinding, reporting and referral, confidentiality guidelines, training, and funding).

There are two essential characteristics within any protective services system: 1) the need for pre-planned individual case responses or protocols which will enable the system and its individual workers to respond quickly and properly to cases and 2) the capacity for a coordinated, interdisciplinary response on the part of the service system to both the emergency and the chronic conditions exhibited by those cases.

Communities can undertake this development activity now, regardless of the state's administrative or legislative responses to the problem of elder abuse. Legal Research and Services for the Elderly staff are beginning to develop model protocols as part of their activities under a Title XX (of the Social Security Act) training grant for workers who deal with abused elders.

As abuse is a multidimensional problem, resolution requires input from many service agencies. Services available in a given community must be coordinated around individual cases. An efficient means of developing this coordinated response is the formation of a protective services committee composed of representatives who agree to provide services to abused elders. The committee's role is to establish linkages between agencies that will allow service coordination to take place in a timely manner; this includes the development of protocols and provision for a continuing review mechanism for individual cases. This dual function might be handled by a single interagency committee, two groups, or a team from one agency assigned by the community to deal with cases of elder abuse.

Services required by individual clients will differ, but a protective services network should provide a basic group of core services, many of which are now available in most communities. These can be provided through one umbrella agency or through formal agreements between providers. The core services include a protective service worker, a case assessment team or worker, primary health care services, legal services, homemaker/home health aide services, transportation, nutrition services, financial assistance, access to police, emergency services, and follow-up. Additional and important support services which could be used but are largely unavailable in most communities include emergency shelter/housing, counseling groups for abused and abuser, foster care for elders, day care, and recreational activity centers.

Most persons participating in a protective services system for abused elders require training. Traditional skills in case management, record keeping, community organization, and case work are identified as essential to the successful handling of abuse cases.

According to the authors of "Service Systems Analysis," training can best be accomplished through state financed and organized efforts. The materials covered in a one-day training session conducted by the Legal Research and Services for the Elderly staff are included in an appendix to the reports. The session included the following: 1) an overview of abuse; 2) a summary of the Massachusetts survey on abuse of the elderly; 3) the theory, strategies, and local resources of adult protective services; 4) relevant statutes and legal abuses; 5) an interdisciplinary model of service provisions; and 6) case hypotheticals presented in small discussion groups. This material is recommended as a helpful guide to those involved in worker training.

Adult abuse cases involved certain common problems for the protective services worker. These have to do with the unwillingness or inability of some abused individuals to consent to services or even to acknowledge the existence (or potential existence) of abuse. Although it is not possible to present a definitive set of guidelines for handling such cases, the initial steps in this task have been taken. Four basic client typologies which protective service systems for elders will encounter are identified by the authors. They suggest the need for specific training and systems building around these basic case models.

The most straightforward and least frequent type of case protective services workers will encounter is the consenting client who appears to be mentally competent. The worker's role in such a case includes arranging for assessment, developing a services plan with the client and the family, working with the client's family to deal with the problem, and, if necessary, coordinating efforts with the client's attorney or providing assistance to the client in obtaining services.

Different issues arise with the non-consenting alleged abuse victim who appears to be mentally competent. Families of such individuals may also refuse the worker access to the home or to the victim. Workers in this situation face an immediate access problem. They have no legal authority to enter the home of an alleged victim of abuse. Should authority be provided through abuse legislation, workers still will be faced with potentially hostile households, with elderly individuals who fear retribution or feel shame about being abused and thus refuse services.

In such cases the worker's initial approach to the family and the victim may help to set the tone for future discussions. It may also increase the possibility of eventual service delivery. The worker's goal is to try to assure the safety of the victim and to deal with the problems leading to the abusive act(s). In some instances, confronting the fact that violence or mismangement has occurred may be unnecessary. Easing some of the caretaker's burden may be all that is needed to reestablish peace in the family unit. In instances of repeated and malicious violence, the worker may have to confront the victim with the continuing danger of his/her situation and the need to take legal action against the abuser. Despite the frustrations involved the worker must recognize the client's right to refuse services.

Issues of confidentiality are particularly difficult in this type of case and should be closely examined during the design of the protective services system. The degree to which the system will "walk away" from a non-consenting client or develop alternatives which do not violate the client's right to privacy and self-determination constitutes perhaps the most difficult moral issue which the protective services system and worker will face.

The primary legal issues involved in the case of a consenting or a non-consenting client who appears to lack sufficient mental capacity to make

decisions regarding his/her health care include the client's right to self-determination, a fair hearing, and legal representation. In cases where compentency is in question, the worker must protect the rights of the client. Arrangements must be made for proper legal representation, and there must be adherence to the principle of the "least restrictive alternative." The latter task is difficult. Existing statutes in most states fail to recognize alternative, intermediate forms of guardianship.

All of these situations may confront the worker with an immediate need to protect the victim from further harm. This protection can take several forms: removal of the victim from the abusive environment, removal of the abuser from the victim's presence, or injecting a third party into the environment who will intervene if abuse threatens. At this time the first alternative is the most widely used, since immediate medical care may be required for the client and because the other alternatives are more difficult to institute.

Some communities are exploring the use of professional and paraprofessional personnel who are sent to live with an abusive family in order to modify the abusive behavior. This obviously requires consent on the family's part, which limits applicability of the technique in emergency situations. Removal of the abuser is legally possible under the terms of the Massachusetts Abuse Prevention Statute, but because no guarantee of the client's safety can be assured, this alternative will probably continue to be used less often in emergency situations than is removal of the victim.

The need for emergency living arrangements for the elderly other than hospitals and nursing homes has already been noted. Workers should also explore the possibility of removing the abuser and moving a third party into the environment, rather than simply depending on removal of the victim. The

system's emergency responses should be planned and agreed upon by all relevant service providers before a case finding is instituted.[40]

Preventive Intervention

It is clear that the American family will require continuing supportive services as its members are increasingly called upon to care for older parents. This need raises the issue of the prevention of parent abuse. Some of the same resources needed to intervene effectively in abuse cases can also be an effective part of a preventive strategy.

The following range of possible resources that could ease the stresses on the caretakers and on the older person are identified in The Battered Elder Syndrome: An Exploratory Study: 1) home-related services in the form of home aides, medical and/or nursing care, meal delivery services, home repair, and home visitors, 2) monetary assistance, 3) day care and respite day care centers, 4) transportation services, 5) counseling and other mental health services, and 6) educational programs focusing on the care of the aged.

Currently, these services are limited to certain areas of the United States or are rare or are only envisioned as possibilities. They are suggested as a supplement rather than a replacement for family care. An additional factor is the need to determine whether a particular service is helpful to both the caregiver and the older person.

A second aspect of a preventive approach is to increase the resources of the older person. The purpose is to promote a feeling of control over one's life, which helps to avoid an image of dependency. Efforts need to be made to reduce the elderly individual's sense of uselessness and boredom and to lessen concern about maintaining independence.[41]

The authors of Behind Closed Doors: Violence in the American Family discuss the need to recognize the existence of two issues when dealing with the problem of violence in the family -- amelioration and prevention. Since violence between family members has only recently been defined as an important problem, there are few resources and techniques available for helping the victim. The needed services are only slowly becoming available. Yet, even with the knowledge and resources to treat the abused family members after violence occurs, the authors maintain that these efforts would be ineffective in reducing the level of violence in the society. Treatment programs and intervention strategies designed to assist violent families are described as "Band-Aids," or "emergency stopgaps." They are used only after a victim is identified.

Attention has already been directed to the "emergency stopgaps" used to deal with parent abuse. The focus now is on the preventive program recommendations offered in Behind Closed Doors: Violence in the American Family. These are aimed at reducing violence in the home. The authors stress that some of the society's most fundamental values and attitudes must be reconsidered and changed if the level of violence in the American family is to be reduced. They maintain that it is these long-standing beliefs which contribute to the high incidence and deadly nature of domestic violence in the United States.

Five steps are recommended. The first is to eliminate the norms which legitimize and glorify violence in the society and in the family. Public awareness campaigns can be used to outline the extent, seriousness, and consequences of violence in the family. The message needs to be conveyed that violence is a fundamental pattern of behavior -- a way of life for families. Strict gun control will help to remove guns from the setting where they do the

most damage -- the American home. Violence committed in the name of the state, e.g., the death penalty, corporal punishment in the schools, and other legally sanctioned violent acts must be eliminated. The glorification of violence on television and in other media must be reduced. A social norm and culture which argues that people -- and this includes children -- are not for hitting must be developed.

The second recommended step is to reduce violence-provoking stresses created by society. The relationship between unemployment and violence suggests that the elimination of unemployment could reduce the level of family violence.

The third step proposed is to integrate families into a network of kin and community. The belief is expressed that whatever can be done to lessen isolation and alienation of modern life is worth investigating.

The fourth recommendation is to change the society's and the family's sexist character. Examination of power, decisionmaking, and sharing of household tasks revealed that inequality in the home is a prime contributor to violence. The family is identified as the outstanding example of a social institution which assigns jobs and responsibilities on the basis of a person's age and sex rather than interest, competence, or ability.

The final recommendation is to break the cycle of violence in the family. Family violence has been reported to carry over from one generation to the next. The authors assert that the level and toll of domestic violence can never be reduced unless this cycle is broken. The majority of American parents consider physical punishment to be necessary. They hold tightly to the notion that spankings are good for children. It is argued that the use of physical punishment must be reduced and gradually eliminated. Alternative techniques for child rearing must be developed. Straus, Gelles, and Steinmetz

conclude that it is possible to raise healthy, happy, and well-behaved children without resorting to violence.[42]

Public Policy Formulation

The Battered Elder Syndrome: An Exploratory Study addresses the issue of public policy. Block, Davidson, and Sinnott report that currently there is no public policy in the United States that is specifically designed to alleviate the problems created by family violence against elders. They identify an immediate need for policy formulation in this area in order to guarantee that goals are achieved effectively and with efficient resource use. Three levels of policy are discussed in an ascending order -- nominal, procedural, and material.

The nominal level of public policy simply acknowledges the existence of the social problem in question. The assumption is that adequate available services exist to deal with the problem, but this is not necessarily the case.

The procedural level of public policy develops special procedures for dealing with the social problem. In the context of elder abuse, agencies might consider procedures to deal with elders at risk. Bureaucratic attention is directed to the problem, although specific resources are not allocated at this level.

At the material level of public policy, resources are assigned. These are usually financial and for explicit purposes -- research grants, intervention and prevention programs, and buildings.

Public policy related to elder abuse in the United States does not exist, even at the lowest of the three policy levels. Most professionals dealing with the elderly have failed to acknowledge abuse of their clients as a serious problem. The authors identify the need for policy development at the

material level in order to deal with the complexities of this problem. Their discussion of public policy refers to this highest level. The focus of the lower levels is established in the process of dealing with the material level.

Adequate policy at the material level must be developed to meet the following criteria: 1) rapid identification of elders at risk in order to minimize the victimization to which they are subject; 2) the immediate availability of effective protection when danger threatens; 3) long-term solutions; and 4) both prevention and intervention strategies.

Attention is focused on the law as a means of implementing public policy regarding abuse of the elderly. Block, Davidson, and Sinnott maintain that an Elder Abuse Prevention and Treatment Act to establish a national center on elder abuse and neglect would be a significant step in controlling violence against the aged. The tasks of such a center would be 1) to compile, analyze, and publish an annual summary of recent research pertaining to elderly abuse, 2) to maintain an information clearinghouse on all programs showing success in the prevention of abuse, 3) to compile and publish training materials for professionals working with the problem, 4) to provide technical assistance to agencies in the form of planning, improving, developing, and carrying out programs and activities, 5) to conduct research into cases of elder abuse, 6) to undertake a complete study of the national incidence of elder abuse, and 7) to appoint an Advisory Board of Elder Abuse and Neglect and mandate it to assist in the development of federal standards for elder abuse and neglect prevention and treatment programs and projects.

The authors suggest that an Elder Abuse Prevention and Treatment Act should also mandate research monies for developing and establishing training programs for professional and paraprofessional personnel.

Those individuals responsible for reporting suspected cases of elder abuse should be designated within settings where dependent abuse is typically encountered. These settings should also establish crisis centers and 24-hour hotlines that serve defined geographic areas and are staffed by multidisciplinary teams of trained personnel. Funds should be employed to provide teams of trained professionals and paraprofessionals in small communities that cannot provide these services on their own. There also should be funds available for initiating innovative programs and projects.

Finally, the authors conclude that an Elder Abuse Treatment and Prevention Act should require states to have in effect an elder abuse mandatory reporting law, which would provide for an immediate investigation upon receipt of an abuse report. Law enforcement officials and state agencies providing human services should cooperate and quickly investigate abuse reports. States should be able to demonstrate that their administrative procedures deal effectively with elder abuse. The confidentiality of all records should be preserved in order to protect the rights of all individuals involved in elder abuse cases. [43]

FOOTNOTES

[1]Suzanne K. Steinmetz, "Battered Parents," Society 15 (July/August 1978):54.

[2]Ibid., p. 54.

[3]Marilyn R. Block and Jan D. Sinnott, eds., The Battered Elder Syndrome: An Exploratory Study (College Park, Md.: University of Maryland, 1979), p. 67.

[4]Elizabeth E. Lau and Jordan I. Kosberg, "Abuse of the Elderly by Informal Care Providers," Aging 299-300 (September/October 1979):12.

[5]Helen O'Malley, Howard Segars, Ruben Perez, Victoria Mitchell, and George M. Knuepfel, "Elder Abuse in Massachusetts: A Survey of Professionals and Paraprofessionals" (Boston: Legal Research and Services for the Elderly, 1979), p.2.

[6]Richard L. Douglass, Tom Hickey, and Catherine Noel, "A Study of Maltreatment of the Elderly and Other Vulnerable Adults" (Ann Arbor: University of Michigan), p. 40.

[7]Block and Sinnott, pp. 69-73.

[8]O'Malley, Segars, Perez, Mitchell, and Knuepfel, p. i.

[9]Lau and Kosberg, p. 11.

[10]Douglass, Hickey, and Noel, pp. 27-36.

[11]Block and Sinnott, pp. 78-79.

[12]O'Malley, Segars, Perez, Mitchell, and Knuepfel, pp. 17-18.

[13]Lau and Kosberg, p. 12.

[14]Douglass, Hickey, and Noel, pp. 45-63.

[15]Block and Sinnott, p. 75-76.

[16]Lau and Kosberg, pp. 11-13.

[17]O'Malley, Segars, Perez, Mitchell, and Knuepfel, p. 39.

[18]Douglass, Hickey, and Noel, pp. 60-61.

[19]Block and Sinnott, p. 77.

[20]O'Malley, Segars, Perez, Mitchell, and Knuepfel, pp. 31-32.

[21]Lau and Kosberg, p. 12.

[22]Block and Sinnott, pp. 73-74.

[23]O'Malley, Segars, Perez, Mitchell, and Knuepfel, pp. 11-13.

[24]Lau and Kosberg, pp. 14-15.

[25]Douglass, Hickey, and Noel, pp. 39-46.

[26]Block and Sinnott, p. 79.

[27]O'Malley, Segars, Perez, Mitchell, and Knuepfel, pp. 37-40.

[28]Lau and Kosberg, pp. 14-15.

[29]Douglass, Hickey, and Noel, pp. 66-67.

[30]Murray A. Straus, Richard J. Gelles, and Suzanne K. Steinmetz, Behind Closed Doors: Violence in the American Family (Garden City, NY: Anchor Press/ Doubleday, 1980.

[31] Ibid., p. 121.

[32]Suzanne Sedge, "Violence in American Society," in The Battered Elder Syndrome: An Exploratory Study, eds. Marilyn R. Block and Jan D. Sinnott (College Park, Md: University of Maryland, 1979), pp. 5-16.

[33]Helen O'Malley, "Elder Abuse: A Review of the Literature" (Boston: Legal Research and Services for the Elderly, 1979), pp. 12-13.

[34]Janice L. Davidson, "Elder Abuse," in The Battered Elder Syndrome: An Exploratory Study, eds. Marilyn R. Block and Jan D. Sinnott (College Park, Md.: University of Maryland, 1979), pp. 52-55.

[35]Steinmetz, p. 54.

[36]Janice L. Davidson, Susan Hennessey, Suzanne Sedge, "Additional Factors Related to Elder Abuse," in The Battered Elder Syndrome: An Exploratory Study, eds. Marilyn R. Block and Jan D. Sinnott (College Park, Md: University of Maryland, 1979), p. 57.

[37]Marilyn R. Block and Janice L. Davidson, "Proposed Mandatory Reporting Law," in The Battered Elder Syndrome: An Exploratory Study, eds. Marilyn R. Block and Jan D. Sinnott (College Park, Md.: University of Maryland, 1979), pp. 97-106.

[38]"Legal Analysis" (Boston: Legal Research and Services for the Elderly), pp. 37-65.

[39]Marilyn R. Block, Janice L. Davidson, and Jan D. Sinnott, "Elder Abuse and Public Policy," in The Battered Elder Syndrome: An Exploratory Study, eds. Marilyn R. Block and Jan D. Sinnott (College Park, Md.: University of Maryland, 1979), p. 89.

[40]"Service Systems Analysis" (Boston: Legal Research and Services for the Elderly), pp. 70-95.

[41]Block, Davidson, and Sinnott, pp. 93-95.

[42]Straus, Gelles, and Steinmetz, pp. 222-244.

[43]Block, Davidson, and Sinnott, pp. 85-88.

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